Adult ADHD Self-Report Screening Scale for DSM-5 (ASRS-5)

NAME: ______________________________ **DATE:** ____________________

	Check the box that best describes how you have felt and conducted yourself over the past 6 months. In case you have been taking stimulant medication, please consider the way you would behave without it.	**0**	**1**	**2**	**3**	**4**
1	How often do you have difficulty concentrating on what people are saying to you even when they are speaking to you directly?					
2	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
3	How often do you have difficulty unwinding and relaxing when you have time to yourself?					
4	When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves?					
5	How often do you put things off until the last minute?					
6	How often do you depend on others to keep your life in order and attend to details?					
	N = Never (**0**), R = Rarely (**1**), S = Sometimes (**2**), O = Often (**3**), VO = Very often (**4**)					

Total score	